Medical History Questionnaire

Name:_____ **Date:**_____ /_____ / _____

Address:_____**Home Phone:** _____**Cell Phone**_____

City: _____**State**_____ **Zip:**_____ **Birth Date:** _____/_____/_____ **Age:** _____

Social Security #: _____/_____/_____ **Occupation:** _____ **Work Phone:**_____

Medical Insurance: _____ **Vision Insurance:** _____

Insurance holder: _____ **Relationship to you:** _____**Last eye exam:** ___/___/_____

Name of primary care doctor:_____ **Your email:** _____

Do you wear glasses? Yes ____ No _____ how old is your current pair of glasses? _____

Do you wear contacts? Yes __ No ___What brand? _____If not, are you interested in contacts? Yes___ No ___

Medical History

Do you have any allergies to medications? Yes ___ No___ If yes, explain: _____

List any medications you take: _____

_____

List any major injuries, surgeries and /or hospitalizations you have had: _____

_____

Circle any of the following that you have had: Crossed eye Lazy eye Drooping eyelid Glaucoma Retinal disease

Cataracts Eye infections Eye injury Other:_____

Are you pregnant or nursing Yes____ No _____

Family History

Please note any family history (parents, grandparents, siblings, and children) for the following conditions:

Disease/Condition	NO	YES	?	Relationship to you
Blindness	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Other _____	☐	☐	☐	_____

Please turn this form over to complete side two

Social History (This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.)

☐ Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you drive? Yes ☐ No ☐ If yes, do you have visual difficulty when driving? Yes ☐ No ☐ If yes please describe:

_____

Do you smoke? Yes ☐ No ☐ If yes, amount/how long? _____ Do you drink alcohol? Yes ☐ No ☐ If yes, amount? _____

Do you use illegal drugs? Yes ☐ No ☐ If yes, type/amount/how long? _____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Review of the Systems

Do you currently, or have you ever had any problems in the following areas:

System	YES	NO	?
Constructional			
Fever, Weight Loss/Gain	___	___	___
Integumentary (skin)	___	___	___
Neurological			
Headaches	___	___	___
Migraines	___	___	___
Seizures	___	___	___
Eyes			
Loss of Vision	___	___	___
Blurred Vision	___	___	___
Distorted Vision/Halos	___	___	___
Loss of Side Vision	___	___	___
Double Vision	___	___	___
Dryness	___	___	___
Mucous Discharge	___	___	___
Redness	___	___	___
Sandy or Gritty Feeling	___	___	___
Itching	___	___	___
Burning	___	___	___
Foreign Body Sensation	___	___	___
Excess Tearing/Watering	___	___	___
Glare/Light Sensitivity	___	___	___
Eye Pain or Soreness	___	___	___
Chronic Infection of Eye	___	___	___
Sties or Chalazion	___	___	___
Flashes/Floaters in Vision	___	___	___
Tired Eyes	___	___	___
Endocrine			
Thyroid/Other Glands	___	___	___

Ears, Nose, Mouth, Throat	YES	NO	?
Allergies/Hay Fever	___	___	___
Sinus Congestion	___	___	___
Runny Nose	___	___	___
Post-Nasal Drip	___	___	___
Chronic Cough	___	___	___
Dry Throat/Mouth	___	___	___
Respiratory			
Asthma	___	___	___
Chronic Bronchitis	___	___	___
Emphysema	___	___	___
Vascular/Cardiovascular			
Diabetes	___	___	___
Heart Pain	___	___	___
High Blood Pressure	___	___	___
Vascular Disease	___	___	___
Gastrointestinal			
Diarrhea	___	___	___
Constipation	___	___	___
Genitals/Kidneys/Bladder	___	___	___
Bones/Joints/Muscles			
Rheumatoid Arthritis	___	___	___
Muscle Pain	___	___	___
Joint Pin	___	___	___
Lymphatic/Hematologic			
Anemia	___	___	___
Bleeding Problems	___	___	___
Allergic/Immunologic	___	___	___
Psychiatric	___	___	___

If you answered YES to any of the above or have condition not listed, please explain: _____

_____

_____

Doctor's signature _____ Date _____

Dr. John L. Meyers and Associates

Patient Financial Responsibility Form

Thank you for choosing Dr. Meyers and Associates as your provider. We are committed to provide you with highest quality care. We ask you to read and sign this form to acknowledge your understanding of our patients financial responsibility policies.

Patient financial responsibilities:

1. The patient (or patients guardian if a minor) is ultimately responsible for the payment for treatment and care
2. We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
3. Patient is responsible for copays, coinsurance, deductibles and all other procedures, tests and treatments not covered by their insurance plan.
4. Copays are due at the time of service.
5. By my signature below, I hereby authorize assignment of financial benefits directly to Dr. Meyers and Associates for services rendered as allowable under third party contracts. I understand that I am financially responsible for charges not covered by this assignment.
6. By my signature below, I authorize Dr. Meyers and Associates personnel to communicate to me by mail, phone and/or voice mail message, according to the information I have provided.
7. I understand that it is **MY** responsibility to know terms of my insurance coverage and that I will be responsible if services exceed the limits of my plan.
8. I authorize Dr. Meyers and Associates to release to my insurance carrier and its agents any information needed to determine benefits for related services.
9. I assign the benefits from my insurance carrier to this practice.

Patient's Signature _____ Date _____ Patient's Printed Name _____

HIPAA Privacy Notice

By signing below, I acknowledge that I have read Dr. John Meyers and Associates privacy notice (HIPAA)

Patient's Signature _____ Date _____ Patient's Printed Name _____